State/Territory California

Citation | Condition or Requirement

REIMBURSEMENT FOR SHORT-DOYLE/MEDI-CAL

ACUTE INPATIENT SERVICES

The policy of the State Agency is that reimbursement for Short-Doyle/Medi-Cal services shall be limited to the lowest of published charges, Statewide Maximum Allowances (SMAs), negotiated rates, or actual cost if the provider does not contract on a negotiated rate basis. To provide mutually beneficial incentives for efficient fiscal management, providers contracting on a negotiated rate basis shall share equally with the Federal Government that portion of the Federal reimbursement that exceeds actual cost. In no case will payments exceed SMAs.

A. **DEFINITIONS**

"Published charges" are usual and customary charges prevalent in the public mental health sector that are used to bill the general public, insurers, and other non-Title XIX payors. (42 CFR 447.271 and 405.503(a))

"Statewide maximum allowances" are upper limit rates, established for each type of service, for a unit of service. A unit of service is defined as a patient day for acute hospital inpatient services. Maximum allowances are established, and effective for, each state fiscal year.

"Negotiated rates" are fixed, prospective rates of reimbursement, subject to the limitations described in the first paragraph above.

"Actual cost" is reasonable and allowable cost, based on year-end cost reports and Medicare principles of reimbursement as described at 42 CFR Part 413 and in HCFA Publication 15-1.

"Provider" means each legal entity providing Short-Doyle/Medi-Cal services.

"Legal entity" means each county mental health department or agency and each of the corporations, partnerships, agencies, or individual practitioners providing public mental health services under contract with the county mental health department or agency.

B. REIMBURSEMENT METHODOLOGY FOR NON-NEGOTIATED RATE PROVIDERS

REIMBURSEMENT LIMITS

The reimbursement methodology for non-**NEGOTIATED RATE PROVIDER** Short-Doyle/Medi-Cal services, by legal entity, is based on the lowest of:

1. The provider's published charge to the general public, unless the provider is a **NOMINAL CHARGE PROVIDER** (as defined below).

2. The provider's allowable cost.

3. The SMAs established as defined in Section D. by the Department of Mental Health (DMH) and approved by the Department of Health Services (DHS).

The above reimbursement limits are applied at the time of settlement of the year-end cost report after determination of Nominal Charge status and are applied individually to each hospital provider.

NOMINAL CHARGE PROVIDER

Determination of Nominal Charge status is the first step in the cost report settlement process, before application of reimbursement limits. Pursuant to Medicare rules at 42 CFR 413.13, public providers and non-public providers with a significant portion of low-income patients are reimbursed the lower of actual cost or SMAs if total charges are 60 percent or less of the reasonable cost of services represented by the charges. The determination of nominal charges for inpatient hospital services is made in accordance with Medicare rules at 42 CFR 413.13(f)(2)(iii).

C. REIMBURSEMENT METHODOLOGY FOR NEGOTIATED RATE PROVIDERS

REIMBURSEMENT LIMITS

The reimbursement methodology for **NEGOTIATED RATE PROVIDER** Short-Doyle/Medi-Cal services, by legal entity, is based on the lowest of:

1. The provider's published charge to the general public, unless the provider is a **NOMINAL CHARGE PROVIDER** (as defined below),

2. The provider's negotiated rates, based on historic cost, approved by the State,

3. The SMAs established as defined in Section D. by the DMH and approved by the DHS.

The above reimbursement limits are applied at the time of settlement of the year-end cost report after determination of Nominal Charge status and are applied individually to each hospital provider. If reimbursement to a negotiated rate provider exceeds actual costs in the aggregate, 50 percent of the Federal Financial Participation (FFP) that exceeded actual costs will be returned to the Federal government.

NOMINAL CHARGE PROVIDER

Pursuant to Medicare rules at 42 CFR 413.13, public providers and non-public providers with a significant portion of low-income patients are reimbursed the lower of negotiated rates or SMAs if total charges are 60 percent or less of the reasonable cost of services represented by the charges. The determination of nominal charges for inpatient hospital services is made in accordance with Medicare rules at 42 CFR 413.13(f)(2)(iii).

D. SMA METHODOLOGY

The SMAs are based on the statewide average cost of a hospital inpatient day as reported in year-end cost reports for the most recent year for which cost reports have been completed. County administrative and utilization review costs are isolated and not included in the direct treatment payment rates. After eliminating hospitals with rates in excess of one standard deviation from the mean, the top ten percent of providers with the highest rates are eliminated from the base data to afford cost containment and allow for an audit adjustment factor. The total remaining costs of hospital inpatient services are then divided by the total number of patient days to arrive at a statewide average rate. The adjusted average rates are inflated by a percentage equivalent to the medical component of the national Consumer Price Index for the period between the cost report year and the year in which the rates will be in effect.

The State Fiscal Year 1989-90 cost report data will be used to develop base rates. The rates from the base year will be adjusted for inflation annually by applying the medical component of the national Consumer Price Index. When the SMAs are re-based in no more than three years, the cost report data will be adjusted to reflect the lower of actual costs or the SMA's in effect for the base year.

State/Territory California

Citation | Condition or Requirement

REIMBURSEMENT FOR FEE-FOR-SERVICE MEDI-CAL

PSYCHIATRIC INPATIENT HOSPITAL SERVICES

Notwithstanding any other provision of this Plan, the policy of the State Agency is that reimbursement for psychiatric inpatient hospital services to Fee-for-Service/Medi-Cal providers shall be the lower of the provider's customary charges or fixed per diem rates.

A. **DEFINITIONS**

"Mental Health Plan" (MHP) means an entity which enters into an agreement with the State to provide beneficiaries with psychiatric inpatient hospital services. A MHP may be a county, counties acting jointly, or another governmental or nongovernmental entity.

"Border community" means a town or city outside, but in close proximity to, the California border.

"Administrative day services" means services for a beneficiary residing in an acute psychiatric inpatient hospital when, due to a lack of residential placement options at non-acute treatment facilities, the beneficiary's stay at the acute psychiatric inpatient hospital must be continued beyond the beneficiary's need for acute care.

"Fee-for-Service/Medi-Cal provider means a provider who submits claims for Medi-Cal psychiatric inpatient hospital services through the State's fiscal intermediary.

"Hospital-based ancillary services" means services other than routine services that are received by a beneficiary admitted to a psychiatric inpatient hospital.

"Routine services" means bed, board, and all medical, nursing, and supportive services normally provided to an inpatient by an acute psychiatric inpatient hospital. Routine services do not include hospital-based ancillary services or physician or psychologist services that are separately billed.

"Allowable psychiatric accommodation code" means a reimbursable hospital billing code, based on room size and type of service, that may be used by Fee-for-Service/Medi-Cal providers to claim payment for psychiatric inpatient hospital services provided to beneficiaries.

B. RATE SETTING FOR PSYCHIATRIC INPATIENT HOSPITAL SERVICES FOR CONTRACT, FEE-FOR-SERVICE/MEDI-CAL PROVIDERS.

1. Reimbursement for acute psychiatric inpatient hospital services for each Fee-for-Service/Medi-Cal provider shall be based on a per diem rate established through negotiations between the provider and the Mental Health Plan (MHP) county in which the provider is located except when:

    a. The MHP from the county in which the provider is located delegates the rate negotiation responsibilities to an MHP in another county with the agreement of that MHP.

    b. The provider is located in a border community and an MHP wants to negotiate rates. The MHP shall request approval from the Department of Mental Health (DMH) to be designated as the negotiator.

    c. A provider is owned or operated by the same organizational entity as the MHP, in which case, the per diem rate must be approved by DMH.

2. The per diem rate shall include routine services and all hospital-based ancillary services.

3. Only one rate for each allowable psychiatric accommodation code for each Fee-for-Service/Medi-Cal provider may be established and shall be used by all MHPs. The negotiated rate shall not be subject to retrospective adjustment to cost.

4. Reimbursement for administrative day services shall be based on the prospective class median rate for nursing facilities that are distinct parts of acute care hospitals and offer skilled nursing services, plus an allowance for the cost of ancillary services equal to 25 percent of the prospective class median rate.

5. For both acute psychiatric inpatient hospital services and administrative day services, interim reimbursement to the provider shall be based on the per diem rate, net of third party liability and patient share of cost, but never to exceed the provider's customary charge.

6. The provider shall bill its customary charges.

7. At the end of each fiscal year, DMH shall compare, in aggregate, customary charges to per diem rate for each provider. Future claims shall be offset by the amount that the per diem rate exceeds the customary charges for that fiscal year.

8. The Medi-Cal payment constitutes payment in full.

9. These provisions will be in effect from January 1, 1995, until such time as the State's pending and related 1915(b) waiver is approved.

C. **RATE SETTING FOR PSYCHIATRIC INPATIENT HOSPITAL SERVICES FOR NON-CONTRACT, FEE-FOR-SERVICE/MEDI-CAL PROVIDERS**

1. Reimbursement rates for acute psychiatric inpatient hospital services for each Fee-for-Service/Medi-Cal provider with no contract with any MHP, shall be determined by DMH.

    a. The reimbursement rates in (1.) shall be calculated by DMH prior to the beginning of each fiscal year and shall not be modified for subsequent rate changes among contract providers or the addition of new contract providers.

    b. One rate per allowable psychiatric accommodation code per non-contract, Fee-for-Service/Medi-Cal provider per Rate Region listed in (9.) shall be established and shall be used by all MHPs.

    c. The rates shall not be subject to retrospective adjustment to cost.

2. The per diem rate includes routine services and all hospital-based ancillaries.

3. The per diem rate shall equal the weighted average per diem rates negotiated for all Fee-for-Service/Medi-Cal providers within the Rate Region where the non-contract provider is located and shall be based on the following information from each Fee-for-Service/Medi-Cal hospital with a contract in the Rate Region where the non-contract provider is located:

    a. The latest available fiscal year Medi-Cal paid claims data for Fee-for-Service/Medi-Cal acute psychiatric inpatient hospital services patient days.

b. The negotiated per diem rates for the subsequent fiscal year.

4. Reimbursement for administrative day services shall be based on the prospective class median rate for nursing facilities that are distinct parts of acute care hospitals and offer skilled nursing services, plus an allowance for the cost of ancillary services equal to 25 percent of the prospective class median rate.

5. For both acute psychiatric inpatient services and administrative day services, interim reimbursement to the non-contract, Fee-for Service/Medi-Cal provider shall be based on the calculated per diem rate, net of third party liability and patient share of cost, but never to exceed the provider's customary charge.

6. The provider shall bill its customary charges.

7. At the end of each fiscal year, DMH shall compare, in aggregate, the customary charges to the per diem rate for each provider. Future claims shall be offset the amount that the per diem rate exceeds the customary charges for that fiscal year.

8. The Medi-Cal payment constitutes payment in full for acute psychiatric inpatient hospital services.

9. The Rate Regions are:

   a. Superior - Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama and Trinity Counties and the border communities of Grants Pass, Klamath Falls, Lakeview, and Medford, Oregon.

   b. Central Valley - Alpine, Amador, Calaveras, El Dorado, Fresno, Kings, Madera, Mariposa, Merced, Mono, Placer, Sacramento, San Joaquin, Stanislaus, Sutter, Tulare, Tuolumne, Yolo and Yuba Counties and the border communities of Carson City, Incline Village, Reno, and Sparks, Nevada.

   c. Bay Area - Alameda, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano and Sonoma Counties.

d. Southern California - Imperial, Inyo, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara and Ventura Counties and the border communities of Las Vegas, and Yerington, Nevada, and Kingman and Yuma, Arizona.

e. Los Angeles County

10. These provisions shall take effect January 1, 1995.

FAX TRANSMISSION COVER SHEET

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REMARKS:

California Mystery Payers

ATTACHMENT 4.19A: DESCRIPTION OF METHODS AND STANDARDS USED TO DETERMINE RATES FOR PAYMENT OF HOSPITAL INPATIENT SERVICES

The California Medi-Cal program will utilize two general approaches for reimbursement of hospital inpatient services. The first approach, cost-based reimbursement will be in effect until the Selective Provider Contracting Program is implemented in a given geographic area. When selective contracting is implemented, the second approach of reimbursement which relies on negotiated contractual arrangements will go into effect. Reimbursement of long-term care services will not be affected by the implementation of selected provider contracts for inpatient hospital services in any area of the State. The payments under the negotiated and competitive bid contracts are expected to be consistent with efficiency, economy, and quality of care, and will not exceed the hospital's customary charges. The rates provided under cost-based reimbursement have and will continue to be more than sufficient to be consistent with efficiency, economy and quality care. The contracting approach will only be used as long as the State's 1915(b)(4) waiver is in effect.

Approach One: Cost-Based

Described after the discussion of Approach Two. However, the provisions of the current plan which are presently enjoined will be inoperative during the pendency of any injunction.

Approach Two: Negotiated and Competitive Bid Contracts

I. General Principles

In selected areas of the State, reimbursement for hospital inpatient services provided to Medi-Cal program beneficiaries on or after the effective date of this plan will be limited, with specific exemptions, to those facilities which contract with the Medi-Cal program. Reimbursement for emergency services will be available to all hospitals.

Until the program has been implemented in a given geographic area, hospitals will continue to be reimbursed using the methodology referred to in Approach One of this State Plan Amendment. The program will be considered implemented when at least 100 percent of the projected needed bed capacity for Medi-Cal patients in an area has been provided for.

TRANSMITTAL # 82-12
REC'D ON 7-13-82
APPROVED 12-29-82
10-1-82

II. Definitions

- Negotiation - The act or procedure of arranging or settling by conferring or discussing the price which will be accepted by a hospital for serving Medi-Cal patients.